

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**

**FOR: HEALTH CARE FINANCING ADMINISTRATION**

**TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES**

1. TRANSMITTAL NUMBER:

**02-019**

2. STATE

**MA**

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE  
SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE

**October 1, 2002**

5. TYPE OF PLAN MATERIAL (*Check One*):

☐ NEW STATE PLAN

☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN

☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (*Separate Transmittal for each amendment*)

6. FEDERAL STATUTE/REGULATION CITATION:

**Section 1902(a)(13) and 1902(a)(30) of the Act and  
42 CFR 447.250 through 447.272**

7. FEDERAL BUDGET IMPACT:

**a. FFY03 \$115,575,000**

**b. FFY04 \$136,225,000**

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

**Attachment 4.19-D(4), pp. 14, 14a**

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION  
OR ATTACHMENT (*If Applicable*):

**None (two new pages)**

10. SUBJECT OF AMENDMENT:

**Nursing Facility Services**

11. GOVERNOR'S REVIEW (*Check One*):

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT

☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED

☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

☒ OTHER, AS SPECIFIED:  
**Not required under  
42 CMR 430.12(b)(2)(ii)**

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:

**Douglas S. Brown**

14. TITLE:

**Acting Commissioner**

15. DATE SUBMITTED:

16. RETURN TO:

**Laura Watson  
State Plan Coordinator  
Office of the General Counsel  
Division of Medical Assistance  
600 Washington Street  
Boston, MA 02130**

FOR REGIONAL DIRECTOR USE ONLY	
DATE RECEIVED	DATE APPROVED
EFFECTIVE DATE OF APPROVAL	SIGNATURE OF REGIONAL OFFICIAL
TYPED NAME	
REMARKS	

State Plan under Title XIX of the Social Security Act  
State. Massachusetts  
Institutional Reimbursement: Nursing Facilities

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V. **2002 State Legislative Changes**

- A. **Nursing Facility Assessments.** An adjustment to nursing facility payment rates is established, effective October 1, 2002, to reimburse participating MassHealth nursing facilities for the providers' assessment costs that are incurred for the care of MassHealth members only, reflecting a portion of the providers' total assessment costs. No reimbursement is made for the providers' assessment costs that are incurred for the care of privately paying residents or others who are not MassHealth members.
- B. **Direct Care Staff.** Pursuant to the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, a rate add-on is computed, effective June 1, 2003, for the purpose of funding wages, hours, and benefits of direct care staff of nursing facilities. The add-on is computed using 2000 data and based on the ratio of each facility's direct care expenses adjusted for Medicaid utilization compared to the statewide sum of the statewide direct care expenses adjusted for Medicaid utilization. Each nursing facility must demonstrate that the add-on is expended for increasing the wages, hours, and benefits of direct care staff, increasing the nursing facility's staff-to-patient ratio, or by demonstrably improving the facility's recruitment and retention of nursing staff to provide quality care. DHCFP will conduct a retrospective review of the add-on to verify whether the add-on is expended as intended. DHCFP is further directed to establish financial penalties for noncompliance, including recovery of excess payments from any facility that does not expend the add-on funds as intended.
- C. **Capital Payment Groups.** In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, adjusted capital payment groups are computed for the purpose of funding reasonable capital expenditures by nursing facilities. Depending upon each facility's past capital payment as of July 1, 2002, a revised capital payment is computed, effective June 1, 2003. If a facility's July 1, 2002 capital payment is greater than or equal to \$ 17.29, the facility's revised capital payment will equal its July 1, 2002 capital payment plus \$0.75. For all other facilities, the revised capital payment is computed as follows:

**State Plan under Title XIX of the Social Security Act  
State. Massachusetts  
Institutional Reimbursement: Nursing Facilities**

<b>Capital Payment Effective July 1, 2002</b>	<b>Revised Capital Payment</b>
\$0 - \$4	\$4.50
>\$4 - \$6	\$6.25
>\$6 - \$8	\$8.25
>\$8 - \$10	\$10.25
>\$10 - \$12	\$12.25
>\$12 - \$14	\$14.25
>\$14 - \$16	\$16.25
>\$16 < \$17.29	\$17.29

- D. Multiple Sclerosis Primary Diagnosis.** In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, and Chapter 151 of the Acts of 1996, a rate add-on is computed, effective October 1, 2002, for eligible nursing facilities that serve a patient population of which more than 75% of the residents have a primary diagnosis of multiple sclerosis to reflect the difference between the standard payment amounts for nursing and the actual base year nursing costs of the eligible nursing facility. Therefore, an eligible nursing facility would get full recognition of its actual base year nursing costs in its rates.
- E. Adjustment for Quality and Utilization Standards.** In accordance with the provisions of St. 2002, c. 184, §180, as amended by St. 2002, c. 300, §43, a \$5 per diem rate add-on is computed, effective June 1, 2003, for eligible nursing facilities that: (i) had at least 188 licensed beds in CY 2000; (ii) had Medicaid occupancy of at least 70% or higher in 2000; and (iii) achieved a threshold quality score of at least 118 on the Department of Public Health Survey Performance Tool for the applicable period.